Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Universal DME

Respondent Name
Fedex Ground Package System Inc

MFDR Tracking Number
M4-15-4125-01

Carrier's Austin Representative
Box Number 22

MFDR Date Received
August 21, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We should be paid for services rendered because we have submitted the appropriate paperwork needed for review."

Amount in Dispute: $913.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our position remains the same as stated on the EOB. It is our position that the rental cost of an ILCD, or other related pneumatic compression devices, is not reimbursable when the device is used peri-operatively in the course of an inpatient or ambulatory admission."

Response Submitted by: Broadspire P. O. Box 14351, Lexington, KY 40512-4351

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 30, 2014	E0673, E0675	$913.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - D98 – Reimbursement not recommended in accordance with the official fee schedule guidelines.
   - B50 – No reimbursement recommended as this service should be included in the hospital/ASC billing

- P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies
- D00 – Based on further review, no additional allowance is warranted
- W3 – In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

1. Are the disputed services separately payable?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the submitted codes E0675 and E0673 as, B50 – "No reimbursement recommended as this service should be included in the hospital/ASC billing." 28 Texas Administrative Code §134.203 (b) states,

   > For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
   >
   > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

   Review of the submitted medical bill finds the place of service found in Box 24B of the CMS 1500 is 22 or "Outpatient Hospital". The CMS Claim Processing Manual, Chapter 20, 10.2 - Coverage Table for DME Claims (Rev. 1, 10-01-03) B3-2105 states, "2. DME must be for use in patient's residence other than a health care institution. (BPM §110.3 & PIM, Chapter 5, §1) 2. Payment cannot be made for equipment for use in an institution classified as: a. A participating hospital, b. An emergency hospital…" and the Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services,110 - Durable Medical Equipment – General (Rev. 1, 10-01-03),B3-2100, A3-3113, HO-235, HHA-220, states, "Expenses incurred by a beneficiary for the rental or purchases of durable medical equipment (DME) are reimbursable if the following three requirements are met:, • The equipment meets the definition of DME (§110.1);, • The equipment is necessary and reasonable for the treatment of the patient's illness or injury or to improve the functioning of his or her malformed body member (§110.1); and, • The equipment is used in the patient's home."

   Based on the above the Carrier's denial is supported as DME is not separately payable when for use in a health care institution. No payment is allowed.
2. The requirements of Rule 134.203 (b) were not met as the requestor is billing for DME for a place of service other than the patient's home. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		September , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.